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No. (1)

In The
Supreme Court of the United States

DIXIE NATIONAL LIFE INSURANCE COMPANY AND NATIONAL FOUNDATION LIFE INSURANCE COMPANY,
Petitioners,

v.

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29.6 of the Rules of this Court, petitioners hereby state that:

Standard Life Insurance Company of Indiana owns 99.5% of Dixie National Life Insurance Company. Standard Life Insurance Company of Indiana's parent company is Capital Assurance Corporation. No publicly traded company owns 10% or more of Dixie National Life Insurance Company's stock.

USHEALTH Group, Inc. is the parent corporation of National Foundation Life Insurance Company. Credit Suisse Legacy, LP is the parent company of USHEALTH Group, Inc. and is the parent of Credit Suisse First Boston Private Equity, Inc. No publicly traded company owns 10% or more of National Foundation Life Insurance Company's stock.

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INTRODUCTION

In contravention of foundational principles of federalism and comity, the Fourth Circuit held, without citation to any authority, that the well-reasoned opinion of a state agency with special expertise in the subject matter is not entitled to deference. The Fourth Circuit's decision flies in the face of well-established principles of South Carolina law that courts must defer to state agency interpretations when those interpretations are made pursuant to a statutory grant of authority. The Fourth Circuit's refusal to afford the South Carolina Department of Insurance (DOI) any deference to its well-reasoned interpretation of an insurance policy provision intrusively interjects federal courts into an area deeply rooted in state law. Indeed, Congress has expressly said that the States' continued regulation of the insurance industry is in the best interest of the public. The McCarran-Ferguson Act was enacted precisely to limit federal preemption under the commerce power. Federal courts would gravely undermine that policy if permitted to do what Congress has prohibited itself from doing.

The Fourth Circuit's decision will have profound national effects. It not only upsets fundamental principles expressed in the *Erie* doctrine (by intentionally substituting federal courts' will for well-reasoned state law), but also it introduces uncertainty and unanticipated risk into a vitally important industry whose very financial health rests on risk calculations. If left standing, the Fourth Circuit's decision would undermine the common sense point that policyholders are entitled to the coverage provided in their written insurance contracts, which were reviewed and approved by the

State—no more and no less. The Fourth Circuit's decision also preempts the function of state insurance commissions by brushing aside those agencies' expertise. That federalism-compromising error is particularly egregious here. The Fourth Circuit's decision creates an untenable and illogical interpretation of the term "actual charges"—a term employed in insurance policies across this country. The result: a select few will gain a windfall for which they never contracted or sustained any loss, yet many more insureds will suffer increased insurance premiums. Even worse, insureds could be left holding policies issued by insolvent insurance companies. Accordingly, the Court should grant this petition for certiorari and reverse the decision below. In light of the clarity of the error below and its manifest importance, the Court may wish to consider summary reversal.

OPINIONS BELOW

The Fourth Circuit's decision is reported at Nos. 06-2022, 06-2054, 2007 WL 4293319 (4th Cir. Nov. 29, 2007), and reprinted in the Appendix ("App.") at 1a. The United States District Court for the District of South Carolina's decision is reported at No. 3:03-3239-JFA, 2006 WL 1529398 (D.S.C. May 10, 2006), and reprinted at App. 43a.

JURISDICTION

The Fourth Circuit rendered its decision on November 29, 2007, and denied Dixie and National's timely motion for rehearing and rehearing en banc on January 2, 2008. On March 13, 2008, the Chief Justice granted Dixie and National's request for a 45-day extension of time to file this petition for a

writ of certiorari, up to and including May 16, 2008. This Court has jurisdiction under 28 U.S.C. § 1254.

PERTINENT STATUTORY PROVISIONS

The McCarran-Ferguson Act, provides in pertinent part:

> Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States. [15 U.S.C. § 1011].
>
> ...
>
> The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business. [15 U.S.C. § 1012].

South Carolina Code, Title 38, Chapter 3, Article 1, section 110, Duties of Chief Insurance Commissioner, provides in pertinent part:

> The director or his designee has the following duties: (1) supervise and regulate the rates and service of every insurer in this State and fix just and reasonable standards, classifications, regulations, practices, and measurements of service to be observed and followed by every insurer doing business in this State; ... (2) see that all laws of this State governing insurers or relating to the business of insurance are faithfully executed and make regulations to carry out this title and all other insurance laws of this State, the enforcement or administration of which is not otherwise specifically provided for; ... (4) institute civil actions, either

through his office or through the Attorney General, relative to the business of insurance or the provisions of this title which he considers necessary to institute.

S.C. Code Ann. § 38-3-110.

Chapter 3, section 150 of the same Title provides in pertinent part:

Commissioner, assistants, or agents may conduct examinations, investigations, and hearings. All examinations or investigations provided by this title, unless otherwise provided by any other insurance laws of this State, may be conducted by the director or by one or more of his duly authorized assistants or agents....

S.C. Code Ann. § 38-3-150.

Finally, Chapter 61, section 20 of the same Title provides in pertinent part:

It is unlawful for an insurer doing business in this State to issue or sell in this State a policy, contract, or certificate until it has been filed with and approved by the director or his designee. The director or his designee may disapprove the form if it: (1) does not meet the requirements of law; (2) contains provisions which are unfair, deceptive, ambiguous, misleading, or unfairly discriminatory....

S.C. Code Ann. § 38-61-20.

STATEMENT OF THE CASE

A. Factual Background

The South Carolina legislature has expressly granted the South Carolina Department of Insurance (DOI) statutory authority to regulate the

insurance industry within that State. The DOI's mission is to protect insurance consumers, the public interest, and the insurance marketplace by ensuring the solvency of insurers; by enforcing and implementing the insurance laws of South Carolina; and by regulating the insurance industry efficiently, courteously, responsively, and fairly. The DOI is responsible for regulating 1,450 insurance companies and over 50,000 agents, brokers, adjusters, appraisers and administrators. As part of this authority, the DOI has the express duty to ensure that insurance contracts sold within the State do not contain ambiguous or misleading terms. The DOI is also entrusted to review (and approve) insurance contracts for sale within South Carolina, as well as investigating disputes between insurers and insureds. Where a proposed contract contains ambiguous terms, the DOI is obligated to prohibit its sale within the State. Insurance providers work closely with the DOI to ensure that, before they offer a policy for sale in the State, contract policy provisions and terms are unambiguous and valid under South Carolina law.

Petitioner Dixie National Life Insurance Company underwrote cancer treatment insurance policies issued to thousands of consumers in the southeastern United States, including South Carolina. The Dixie policy is a supplemental benefit insurance policy. App. 44a. Generally, supplemental insurance policies provide cash benefits to an insured for a covered loss, regardless of whether the insured has other primary health

insurance to pay for any portion of that loss.[1] The supplemental insurer therefore pays cash benefits directly to the insured upon its receipt of written proof of loss supporting the claim, regardless of whether the insured's primary health insurance policy has paid any portion of the same loss directly to the insured's health care provider. App. 4a-5a. Because both the primary and supplemental insurance policies require that the insured first sustain a loss (i.e., incur expenses for applicable medical treatment), there is no concern about an insured's "double recovery" for medical treatment covered under both the primary and supplemental policies. *Id.* Supplemental insurance policies frequently provide, as the policy at issue here provides, that when a primary health insurer pays covered medical expenses, the supplemental insurer will only pay the insured supplemental benefits measured by the health care provider's "actual charges" for the covered procedure or treatment. App. 5a.

South Carolina law required Dixie's supplemental cancer policy (the Policy) to be filed with, reviewed by, and approved for sale by the DOI. S.C. Code Ann. § 38-71-310. By approving the policy, the DOI determined that the Policy was not ambiguous, unfair, deceptive, misleading or unfairly discriminatory. *Id.* In December 1993, petitioner,

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[1] Typically, primary health insurance plans contain various calendar year deductibles, co-insurance requirements, and co-payment requirements by the insured, as well as other limitations on coverage. Insureds may use their supplemental insurance benefits to pay these costs.

National Foundation Life Insurance Company, assumed the Policy from Dixie. App. 6a.

Respondent, Martha Ward (Ward), purchased the Policy from Dixie in August 1990. App. 44a. Her husband, James Ward, was listed as an insured under the Policy. *Id.* Ward's Policy provides that certain benefits, including payments for radiation therapy and chemotherapy, are measured based upon the "actual charges" to the insured for such treatments. App. 5a-6a. For example, the Policy provides:

> We will pay for the actual charges for teleradiotherapy, using either natural or artificially propagated radiation, when used for the purpose of modification or destruction of tissue invaded by cancer. We will also pay the actual charges made for plaques or molds or the administration internally, interstitially, or intercavitarially of radium or radioisotopes in sealed sources for the purpose of modification or destruction of tissue invaded by cancer....

Id. The Policy, however, does not specifically define the term "actual charges." *Id.*

In 2001, Mr. Ward was diagnosed with prostate cancer and was treated with radiation therapy. App. 44a. During that treatment, Mr. Ward had primary heath insurance coverage under South Carolina's State Health Plan, which is a preferred provider organization (PPO) plan administered by Blue Cross Blue Shield of South Carolina (BCBS). App. 6a. Under the terms of the Wards' primary health

insurance policy, health care providers agree with BCBS, before rendering any services, to charge and accept certain pre-negotiated contract amounts as payment in full for services rendered to State Health Plan insureds. *Id.* Under the contractual terms of BCBS's agreements with health care providers, a provider is prohibited from billing an insured for any amount greater than the pre-negotiated rates they agreed to accept for their services in advance of performing such services. App. 6a-7a.

Beginning in 2002, Ward submitted claims to National under the Policy using adjusted summary of account statements that she had received from her husband's health care providers. App. 44a. Upon learning that the Wards were covered by the State Health Plan, National requested that Ward submit her husband's Explanation of Benefits (EOB) statements from BCBS because those statements reflect the pre-negotiated rates for the services rendered. App. 45a. National explained to Ward that because "any amounts written-off by a provider cannot be balance billed to insurance companies or the patient [by law], such amounts cannot be considered as actual charges." App. 60a.

Ward refused to provide her EOBs to National. App. 7a. Instead, she maintained that she was entitled to payments based on whatever amount may have been set forth on any provider's statement, regardless of whether the amount exceeded the contractually negotiated charges that the provider had agreed to accept as payment in full for services rendered. App. 62a. In other words, Ward insisted that she was entitled to benefits equaling whatever amount was listed on a provider's statement—even if that amount was never actually billed or represented

an amount that neither she, nor her primary insurance carrier, was legally obligated to pay.

On August 14, 2002, Ward sent a letter to the DOI, complaining that National had improperly refused to pay claims based on her interpretation of the term "actual charges." App. 61a. The DOI began an investigation, and ultimately rejected Ward's complaint. The DOI expressly concluded that National "handled this matter appropriately." App. 63a. In a letter ruling, the DOI stated that "[c]harges by providers that are discounted due to other contracts become the actual charges, as the discounted amount cannot be balance billed to either the insurance company or the patient." *Id.*

Not satisfied with the DOI's response, Ward filed a second complaint with the DOI, requesting "a legal definition" of the term "actual charges" under South Carolina law, as well as an "audit by [the DOI] on the reimbursement laws of cancer policies...." App. 65a-66a. In response, the DOI ruled:

> The term "actual charges" in industry-wide standards is the amount that you are legally obligated to pay for a specific service....
>
> Your Cancer Policy ... is a specified disease policy providing benefits on an expense-incurred basis. When you incur expenses, you are legally obligated to pay those expenses....
>
> Health insurance policies are not meant to provide benefits for services for which the insured person is not legally obligated to pay. Your State Health

> Plan has an agreement with certain providers to accept the Allowable Charge under the Plan as payment in full. Under the agreement, the provider cannot balance bill you for any additional amounts over the Allowable Charge as determined by the State Health Plan. Since you are not legally obligated to pay more than the State Health Plan's Allowable Charge for any specific service, National ... has requested copies of the State Health Plan's Explanation of Benefits (EOBs) to determine how much the provider has agreed to charge you.
>
> National ... is not considering the payment under the State Health Plan but rather excluding that amount that is required to be written off by the State Health Plan.

App. 67a-68a.

The DOI's interpretation of "actual charges" was entirely consistent with its previous rulings on this issue. In a letter opinion issued three years earlier, in 1999, the DOI concluded that it was proper for National to require an insured's EOB to process an "actual charges" claim under the Dixie cancer policy precisely because a "provider may not bill [the insured] more than the approved amount" for services rendered. App. 55a. The DOI also made the very same determination in 2002 before it received Ward's complaint—namely that National had properly sought EOBs from a Dixie policyholder so it could determine the actual charges of services

rendered because "[a]n insurer is not liable for charges, which an [insured] is not legally responsible for." App. 57a.

B. Proceedings Below

Notwithstanding the DOI's consistent interpretation of "actual charges" under the Policy, Ward filed this action against petitioners in South Carolina state court in March 2003. App. 46a. Dixie and National removed the action to the U.S. District Court for the District of South Carolina on October 10, 2003. *Id.* The district court twice granted Ward leave to amend her complaint. Ward's Third Amended Complaint alleged that National refused to reimburse Ward based on the "actual charges" for services rendered, and instead reimbursed Ward based on the negotiated rates between the State Health Plan and the providers. This, according to Ward, was in direct contravention of the policy.

In early 2006, Dixie and National moved for summary judgment, which the district court granted. App. 48a. The district court held that the plain and ordinary meaning of the term "actual charges" is "the charges for which the patient is liable when medical services are rendered, not the fictitious amounts indicated on the invoice that the provider does not expect the patient to pay." App. 52a. In so concluding, the district court properly deferred to the DOI's interpretation of that policy term:

> This finding is in accord with the position taken by the SCDOI. Under well-settled South Carolina law, the SCDOI's construction of the Policy is to

> be accorded respectful consideration and should not be overruled absent compelling reasons. *See, e.g., Dunton v. S.C. Bd. of Exam'rs in Optometry*, 353 S.E. 132, 133 (S.C. 1987).

Id.

Ward appealed. The DOI filed an amicus brief on behalf of Dixie and National's position and once again reiterated its longstanding interpretation of "actual charges" under the Policy. Nevertheless, on October 5, 2007, the Fourth Circuit reversed the district court, holding that the term "actual charges," as used in Ward's policy was ambiguous. App. 30a-34a. Improperly resorting to parol evidence, the Fourth Circuit concluded that "actual charges" is an ambiguous "term of art" as used in the policy and could be reasonably construed to mean either "'the amount that you are *legally obligated to pay for a specific service*," as the DOI had determined, or "the amount billed," as certain health care dictionaries provide.[2] App. 33a (internal quotation omitted) (emphasis in original). Accordingly, the court of appeals vacated the district court's grant of summary judgment and remanded for further proceedings.

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[2] Importantly, the parol evidence cited by the Fourth Circuit notes that the "actual charge may not be the same as that paid for the service by an insurance plan." App. 33a. This is entirely consistent with insurance practices and National's position, in that it recognizes the insured's calendar year deductibles, co-insurance, and co-payment requirements, although not paid under the primary health plan, are properly included as part of the medical provider's actual charge.

Petitioners and Ward both filed motions for panel rehearing. The DOI filed a second amicus brief in support of Dixie and National's motion for rehearing. On November 29, 2007, the Fourth Circuit granted Ward's motion for rehearing, vacated its original panel decision, and entered a new opinion, which not only reversed the district court's grant of summary judgment in Dixie and National's favor, but also granted summary judgment in favor of Ward. In revising its original opinion, the panel concluded that the term "actual charges" was patently ambiguous, which, under South Carolina law, is an ambiguity that must be resolved, as a matter of law, in favor of the insured. App. 12a-13a. In reaching that conclusion, however, the Fourth Circuit expressly declined to defer to the DOI's interpretation of the term "actual charges," instead, substituting its own judgment in place of the state agency's. App. 12a n.3. "National and its supporting amici, [which included the DOI,] contend that, absent compelling reasons, we must defer to the Department of Insurance's interpretation of 'actual charges.' *We disagree.*" *Id.* (emphasis added). Although the panel recognized that under South Carolina law, "an agency's interpretation of a statute it is charged with enforcing is entitled to deference," the panel concluded—despite South Carolina's broad and express statutory grant to the DOI to interpret policies—that the DOI "has no statutory mandate to pronounce the meaning of the term in an individual insurance policy." *Id.*

On December 13, 2007, Dixie and National filed a second petition for panel rehearing or rehearing *en banc*. The DOI submitted a third amicus brief in support of Dixie and National's petition. The Fourth

Circuit denied the petition for rehearing on January 2, 2008.

This petition follows.

REASONS FOR GRANTING THE WRIT

I. The Fourth Circuit's Failure To Defer To The South Carolina Department Of Insurance Improperly Interjects The Federal Courts Into An Area Of Law That Has Been Expressly Left To The States.

The South Carolina legislature has created a comprehensive regulatory scheme for the State's insurance industry. The South Carolina legislature placed the DOI at the helm of this regulatory regime. In its decision below, however, the Fourth Circuit refused to defer to the DOI's well-reasoned interpretation of an insurance policy whose content it had approved and was charged with administering. If allowed to stand, the Fourth Circuit's decision will give federal courts free rein to interject themselves into state insurance regulation, a result that is contrary to Congress's express intention that the States maintain exclusive regulatory authority over insurance matters. Indeed, Congress enacted the McCarran-Ferguson Act, "leaving insurance regulation generally to the States[,] ... to limit congressional preemption under the commerce power." *American Ins. Ass'n v. Garamendi*, 539 U.S. 396, 428 (2003). Federal courts will manifestly undermine that "legislative choice," *id.*, if they are permitted to ignore state insurance commissions' well-reasoned interpretations of insurance policy provisions.

It is axiomatic, in South Carolina and in other States, that where a state agency interprets a statute or regulation it is entrusted to enforce, that interpretation deserves the utmost respect unless it is contrary to the text's plain meaning. *See Richland County Sch. Dist. Two v. South Carolina Dep't of Ed.*, 335 S.C. 491, 498 (1999) (holding that "the deference normally afforded an administrative agency[]" will only be overruled where "the plain meaning of the proviso's language provides a compelling reason to reject [it]").[3]

Under South Carolina law, South Carolina courts give broad deference to state agencies, regardless of whether a state agency has interpreted its statute in a formal adjudication on the merits, notice-and-comment rulemaking, or in an informal policy statement. *See, e.g., South Carolina Life & Accident & Health Ins. Guar. Ass'n v. Liberty Life Ins. Co.*, 545 S.E.2d 270 (S.C. 2001) (refusing to defer to state

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[3] *See, e.g., RME Petroleum Co. v. Wyoming Dep't of Rev.*, 150 P.3d 673, 689 (Wyo. 2007) ("We will defer to an administrative agency's construction of its rules unless that construction is clearly erroneous or inconsistent with the plain meaning of the rules."); *Murphy v. District of Columbia Dep't of Employment Svcs.*, 935 A.2d 1066, 1070 (D.C. 2007) ("[An] agency's interpretation of the statute it administers is binding on this court unless it conflicts with the plain meaning of the statute."); *Dean v. Public Employees' Ret. Sys.*, 797 So.2d 830, 835 (Miss. 2000) ("An agency's interpretation of its governing law is entitled to deference, unless its interpretation is repugnant to the plain meaning ... of the statutes."); *Falk v. Beard*, 614 So.2d 1086, 1089 (Fla. 1993) ("The construction of a rule by the agency charged with its enforcement and interpretation is entitled to great weight. Courts should not depart from that construction unless it is clearly erroneous.").

agency's interpretation of a statute in an informal letter to a petitioner only because that interpretation was in direct conflict with the plain meaning of the statute); *Dunton v. South Carolina Bd. of Exam'rs In Optometry*, 353 S.E.2d 132, 133 (S.C. 1987) ("The construction of a statute by the agency charged with its administration will be accorded the most respectful consideration and will not be overruled absent compelling reasons."). Indeed, the South Carolina Supreme Court recently reaffirmed this principle of deference in *Sloan v. South Carolina Board of Physical Therapists*, 370 S.C. 452 (2006)—a case decided just one year before the Fourth Circuit's decision. In *Sloan*, the South Carolina Supreme Court reiterated that an agency's interpretation of the statute it is charged with administering deserves "the most respectful consideration[, which] should not be overruled absent compelling reasons," *id.* at 469—even though the agency interpretation at issue was "nothing more than a policy or guidance statement which does not have the force or effect of law in any individual case," *id.* at 474.

As a matter of South Carolina law, the DOI has the exclusive statutory duty to regulate insurance companies doing business within South Carolina, including the obligation to ensure that insurers offer policies that are neither ambiguous nor unfair. S.C. Code Ann. § 38-3-110. Because the DOI is a state agency that enjoys a statutory grant of authority to regulate the insurance marketplace in the State, and because it has expertise regarding insurance contracts, South Carolina courts will defer to the DOI when it speaks on an issue concerning the regulation of insurers and will not overrule the

DOI's determinations absent compelling reasons. *E.g.*, *Dunton*, 353 S.E.2d at 133.

The Fourth Circuit's decision is in irreconcilable conflict with this black-letter South Carolina law. The Fourth Circuit expressly rejected petitioners' "conten[tion] that, absent compelling reasons, [it] must defer to the Department of Insurance's interpretation of actual charges." App. 12a n.3. Instead it concluded, without citation to authority, that it was not "require[d] ... to defer to the Department's view of the matter." *Id.*

This destabilizing decision cannot be excused, as the court below attempted to do, by any claim that the DOI "has no statutory mandate to pronounce the meaning of a term in an individual insurance policy." *Id.* South Carolina law clearly provides otherwise: it grants the DOI broad regulatory authority over insurance polices sold within the State. *See* S.C. Code Ann. § 38-3-110. That duty includes an express statutory obligation to ensure that the terms of an insurance policy are unambiguous, as well as the statutory authority to refuse to approve any policies for sale in the State that contain ambiguous or misleading terms. *Id.* The DOI also has expansive statutory authority to investigate and adjudicate disputes between insurers and insureds. *See id.* § 38-3-150. In short, the DOI's regulatory authority is broad and easily encompasses the authority—if not the outright legal obligation—to interpret a provision in a previously approved insurance policy, the meaning of which is subject to dispute between an insurer and insured.

Here, Ward asked for and received a legal interpretation of the term "actual charges" from the DOI. As a result of that request, the DOI, pursuant

to its statutory authority, opened an investigation into the dispute between Ward and National and concluded that the term "actual charges" means "the amount that [insureds] are *legally obligated to pay for a specific service.*" App. 67a (emphasis in original). That is because the subject policy "provide[s] benefits on an *expense-incurred* basis." *Id.* (emphasis added). In other words, the Wards' policy only pays for expenses and losses that an insured has actually suffered. *Id.*

The DOI thus provided Ward with a reasoned interpretation of the precise policy term at issue in this case, and its interpretation was wholly consistent with its previous interpretations of the same policy term. Even assuming that the DOI's opinion letters to Ward do not, by themselves, constitute a formal, definitive ruling by the DOI, the DOI subsequently submitted three amicus briefs to the Fourth Circuit in connection in this appeal (as well as an amicus brief with the district court), each of which unequivocally affirmed and reiterated the DOI's initial rulings. Under such circumstances, "[t]here is simply no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question." *Auer v. Robbins*, 519 U.S. 452, 462 (1997) (Secretary of Labor's interpretation of regulation set forth in amicus brief was entitled to deference); *see also Christensen v. Harris County*, 529 U.S. 576, 591 (2000) (Scalia, J., concurring) (an amicus brief cosigned by the Solicitor General and Secretary of Labor, which represents the position previously set forth by the Department of Labor in an opinion letter, is entitled to *Chevron* deference).

The Fourth Circuit's refusal to defer to the DOI's consistent, well-reasoned interpretation is inexplicable. It is manifestly contrary to South Carolina courts' admonition that agency rulings that fall within their regulatory authority and area of expertise must be given meaningful deference. The Fourth Circuit's decision seems to rest on the court's conclusion that the DOI's administering statute does not charge the DOI with the *specific* task of interpreting an *individual* term in an insurance policy. App.12a n.13. That cannot be the standard for deference. If deference is owed only where an administering statute details each and every act that a state agency must perform to carry out its legislatively-mandated duties, then the principle of agency deference will carry little force. Administering statutes, including the insurance code at issue, often grant an agency broad regulatory authority without filling in all of the details. It is in precisely such circumstances that agency deference should be at its peak. *See Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984) ("The power of an administrative agency to administer a congressionally created ... program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress.") (internal quotation omitted).

If allowed to stand, the Fourth Circuit's decision will give federal courts license to interject themselves into an area of law that Congress has expressly left to the States to regulate. Under the McCarran-Ferguson Act, Congress announced that state regulation of the insurance industry best serves "the public interest." 15 U.S.C. § 1011. That

is precisely why Congress "declare[d] that the continued regulation by the [States]" is the preferred method of regulating the insurance industry. *Id.*; *see also Lac D'Amiante du Quebec, Ltee v. American Home Assur. Co.*, 864 F.2d 1033, 1041 (3d Cir. 1988) ("In the absence of the type of comprehensive federal regulation over insurance accorded the banking, securities and commodities industries, and because of the exclusion of insurance companies from the operation of federal bankruptcy law ... the states have assumed the primary role in regulating insurance."); *cf. Chiropractic Am. v. Lavecchia*, 180 F.3d 99, 107 (3d Cir. 1999) (recognizing that "there is no federal interest in the regulation of automobile insurance, an area in which Congress has deferred to the states"). Indeed, "States, as a matter of tradition and express federal consent, have an important interest in maintaining precise and detailed regulatory schemes for the insurance industry." *Quackenbush v. Allstate Ins. Co.*, 517 U.S. 706, 733, (1996) (Kennedy, J. concurring) (citing McCarran-Ferguson).

Federal courts, therefore, should not be in the business of imposing their judgment where a state insurance commission has already spoken. *See Humana Inc. v. Forsyth*, 525 U.S. 299, 310 (1999) (recognizing that the McCarran-Ferguson Act precludes application of federal law where it "directly conflict[s] with state regulation, and when application of the federal law would ... frustrate [the] declared state policy or interfere with a State's administrative regime"). To allow a federal court to do so is at odds with fundamental principles of *Erie*—the application of state law in an independent and neutral federal forum. Indeed, this Court has

repeatedly emphasized the importance of federalism and comity, particularly when federal courts sit in diversity. It has recognized various prudential doctrines to promote the fundamental objectives of diversity jurisdiction post-*Erie*. For example, federal courts apply various forms of abstention to avoid the misapplication of state law. Under *Thibodaux* abstention, federal courts abstain from deciding state-law questions that are inherently tied to the State's "sovereign prerogative." *Louisiana Power & Light Co. v. City of Thibodaux*, 360 U.S. 25, 28 (1959). Federal courts might also abstain from deciding unresolved questions of state law where the State has created a comprehensive regulatory scheme over the subject of litigation. *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943). The pivotal point is that this Court has admonished federal courts sitting in diversity to ensure that they properly apply state law as the States would apply it. And where state law is unclear, federal courts may, as a prudential matter, abstain to avoid conflicts with the States whose laws they are supposed to be applying.

It would be upside down, therefore, to say (as the Fourth Circuit tacitly did here) that federal courts may abstain on an issue of state law that remains unresolved, but may ignore settled state law as interpreted by the well-reasoned decisions of a State's agency. *Compare First Penn-Pacific Life Ins. Co. v. Evans*, 304 F.3d 345, 348 (4th Cir. 2002) ("Courts should abstain from deciding cases presenting difficult questions of state law bearing on policy problems of substantial public import whose importance transcends the result in the case then at bar, or whose adjudication in a federal forum would be disruptive of state efforts to establish a coherent

policy with respect to a matter of substantial public concern.") (internal quotations omitted), *with* App. 12a n.3 ("National and its supporting amici contend that, absent compelling reasons, we must defer to the [DOI's] interpretation of 'actual charges.' We disagree."). Such an analysis turns *Erie* on its head.

To the contrary, there is an "inherent logic of ... allowing state agencies wider deference in state law determinations." *Michigan Bell Tel. Co. v. MFS Intelenet of Mich., Inc.*, 339 F.3d 428, 433 (6th Cir. 2003); *cf. Kendra Oil & Gas, Inc. v. Homco, Ltd.*, 879 F.2d 240, 242 (7th Cir. 1989) ("[F]ederal courts will defer to the primary jurisdiction of a state agency under the principles established by *Erie,* if state courts would defer."). Deferring to state agency determinations promotes the primary objectives of diversity jurisdiction post-*Erie*—"discouragement of forum-shopping and avoidance of inequitable administration of the laws." *Hanna v. Plumer,* 380 U.S. 460, 468 (1965). If federal courts refuse to apply state-law principles of deference on questions of purely state law, it will "create[] a dual system of enforcement of state-created rights, in which the substantive rule applied to a dispute may depend on the choice of forum." *Salve Regina College v. Russell,* 499 U.S. 225, 234 (1991). Litigants should not be able (much less structurally encouraged) to select a federal forum to avoid the application of state law to their state-law breach-of-contract claims, particularly where the state agency that approved and regulates insurance contracts has already interpreted the very contract provision at issue. This salutary pro-federalism principle has all the more force where, as here, Congress has determined that such insurance contracts are best

regulated by the States. But that flouting of Congress' intent is precisely what the Fourth Circuit's decision would allow here.

Federal courts deeply undermine sound principles of federalism and comity when they refuse to defer to a state insurance agency's well-reasoned determination of an issue of purely state law. This Court should grant this petition for certiorari and reverse the decision below.

II. The Fourth Circuit's Refusal To Defer To The South Carolina Department Of Insurance's Interpretation Of The Term "Actual Charges" Is An Important Issue That Affects Insurance Policies Issued Across Many States.

When it refused to defer to the state agency's interpretation of "actual charges," the Fourth Circuit not only undermined fundamental principles of federalism, but also created a dangerous new precedent, which will affect thousands of insurance policies sold nationwide. In all of these policies, as well as many other supplemental insurance policies, the insured is reimbursed for expenses based on the health care provider's "actual charges." The Fourth Circuit's decision, if allowed to stand, will have the effect of altering the meaning of an unambiguous policy term, a meaning upon which insurers have based their respective risk calculations and set premiums. If insurance contracts are to have any meaning or value, then unambiguous provisions must be interpreted to provide the coverage contracted for—no more and no less. That point is particularly important here because the decision

below will have consequences that reach far beyond South Carolina.

First, insurance companies rely upon state insurance commissions, their primary regulatory bodies, to approve their policies. These commissions, in turn, work with insurance companies to ensure that policy provisions are not infected with ambiguity. *See, e.g.*, Ala. Code Ann. 1975 § 27-14-9 (the commissioner of insurance shall not approve a policy for sale within the State that is ambiguous); Fla. Stat. Ann. § 624.4412 (same); Ga. Code Ann. § 33-24-10 (same); La. Rev. Stat. Ann. § 22:621 (same); Miss. Code Ann. § 83-2-11 (same). When state commissions approve specific terms in a policy, that official approbation helpfully creates needed certainty within the insurance industry. This process is imperative, as it provides insurance companies a clear understanding of the risks they assume *before* selling policies to consumers. Indeed, this is the very basis upon which insurers enter into contracts with insureds. To allow a federal court to spawn uncertainty surrounding the already-approved terms of a policy introduces new risks that neither the state agency nor the insurance company can anticipate. This, in turn, would result in actuarial and financial uncertainty for insurance companies, whose entire financial health rests on calculating and managing these risks. Moreover, the contracts between insurers and insureds will be worth little more than the paper on which they are written.

Second, the Fourth Circuit's decision eviscerates the role of state insurance commissions by authoritatively interposing its judgment in lieu of that of the agencies. This is especially true where,

as here, an agency has performed its statutory obligation to make certain that a particular policy term is clear and unambiguous. *Cf. Muratore v. U.S. Office of Personnel Mgmt.*, 222 F.3d 918 (11th Cir. 2000) (deferring to Office of Personnel Management (OPM) on issue of insurance contract term because "OPM does have relevant expertise in this area because it negotiates the contracts ... and ... routinely interprets plans to determine an insurance carrier's liability"). The problem with the Fourth Circuit's approach is particularly acute where state agencies take a primary role in investigating and adjudicating disputes between insurance companies and insurers. State legislatures, including South Carolina's, have granted agencies the authority to adjudicate claims precisely because of agencies' expertise in the insurance industry. The Fourth Circuit's decision ultimately preempts the role of insurance commissions, making commission approval of an insurance policy and their resolutions of consumer complaints virtually irrelevant.

As this case demonstrates, ignoring the expertise of a state agency can lead to unsound decisions. Here, for example, the Fourth Circuit declared the term "actual charges" patently ambiguous because, according to that court, the term could mean either the amount an insured is legally obligated to pay for services or any amount a provider prints on an invoice, regardless of whether that amount is fictitious or in excess of any amount that the insured legally owes. App. 9a-15a. But the latter interpretation is patently illogical. It rests entirely on the assumption that insureds actually receive an invoice or a bill from their health care providers. This is at odds with modern medical billing practices

where consumers are rarely (if ever) directly billed for services rendered.

Finally, the Fourth Circuit's decision creates a federal precedent regarding the term "actual charges," which will affect insurance policies sold not only in South Carolina, but also in States within the Fourth Circuit and across the nation. The Fourth Circuit's opinion has already been cited positively by the Fifth Circuit. In *Guidry v. American Pub. Life Ins. Co.*, 512 F.3d 177, 184 (5th Cir. 2007), a case where the question of state agency deference was not raised, the Fifth Circuit held that under Louisiana law, the term "actual charges" in the subject supplemental insurance policy was ambiguous. It noted that its "conclusion is supported by the Fourth Circuit's recent decision in [*Ward*]." The Fifth Circuit continued:

> In *Ward*, the Fourth Circuit considered the interpretation of the same term "actual charges," as used in a similar insurance policy, and applied similar rules of contract interpretation under South Carolina law. Like us, the Fourth Circuit determined that the definition of "actual charges" advocated by the insurance companies ... was "not the only one possible when the language of the policy is considered in light of its context.

Id. In other words, the Fourth Circuit's decision (and now *Guidry*) now stand as precedent for an untenable and illogical understanding of the term "actual charges." This will have a profound financial impact on the insurance industry in this country. If

left standing, the Fourth Circuit's decision will result in higher insurance premiums across the country. And in States where insurance commissioners must approve rate increases, the Fourth Circuit's decision may lead to insolvency problems for insurance companies. While the decision will result in a windfall benefit for a few, the interests of most insureds will suffer. Needless to say, the Fourth Circuit's decision will have far-reaching effects well beyond South Carolina. This Court should grant certiorari to address a question of critical importance to insureds and insurers alike. Because of the manifest clarity of the error below, the Court may wish to consider summary reversal.

CONCLUSION

For the foregoing reasons, this Court should grant the petition for writ of certiorari. The Court may also wish to consider summary reversal.

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